STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	C 12/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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F 000	INITIAL COMMENTS	F 000		

This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility from 12/10/07 to 12/12/07.

Complaint NV00016749 alleged that the facility failed to provide an assessment and monitoring of a leg injury to prevent infection of a wound. The complaint was substantiated. A citation was written at F309.

The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.

F 309 SS=D	483.25 QUALITY OF CARE	F 309	

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined that the facility failed to assess and treat a leg wound to prevent infection for one resident.

Findings include:

The resident was admitted to the facility on 9/19/07 with diagnoses including paralysis

This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Hearthstone of Northern Nevada agrees with the allegations and citations listed on the statement of deficiencies. Hearthstone of Northern Nevada maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Hearthstone of Northern Nevada written credible allegation of compliance.

By submitting this plan of correction, Hearthstone of Northern Nevada does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Hearthstone of Northern Nevada reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.

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BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathleen Laure	Administrator	12/28/07

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 309	Continued From page 1 agitans, food/vomit pneumonitis, vascular dementia, and late effects of cerebrovascular disease. On 12/10/07, the resident's medical record was reviewed. Review of the nurses notes revealed that on 12/2/07 , at 10:00 AM, "patient had a fall at this time. Was sitting at nurses station in wheelchair and patient fell forward onto knees. Did not hit his head. No apparent injury. Assisted back into wheelchair by CNA (certified nursing assistant). Denies pain or injury...VS (vital signs) WNL (within normal limits)." At 9:00 PM, on 12/2/07, the nurses notes stated that the resident was resting comfortably with "no apparent injury from fall". The facility's event report for the 12/2/07 event did not describe any injuries from the fall. The nurses notes dated 12/3/07, 3:20 AM, documented the resident was quiet in bed with no signs of distress or discomfort, "noted Band-Aid intact to left outer lower leg. No signs/symptoms any complications from fall." The nurses notes dated 12/4/07, 1:30 AM, documented, "up in wheelchair, fidgeting with pants leg and scratched outer aspect of RLE (right lower extremity), some bleeding noted, cleaned and covered." On 12/5/07, the resident was found unresponsive and was transferred to an acute care hospital. The resident's acute hospital record was reviewed. The resident's vital signs upon arrival in the emergency room , at 8:18 AM, were temperature 99.7, pulse 96, respirations 16 and blood pressure 126/56. The triage note/initial assessment revealed the following skin assessment, "left heel red, wound to left leg, right	F 309	F309 Quality of Care The facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being, in accordance with the comprehensive assessment and plan of care. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; • Resident # is discharged. Accepted MP 1/7/08	

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F 309	Continued From page 2 leg, left leg red". The resident's temperature was recorded as 101.9 at 10:53 AM. The resident had a chest x-ray done 12/5/07, at 9:16 AM, the findings were no acute cardiopulmonary abnormality and minimal bibasilar atelectasis. The resident's white blood count on admission was 28.1, normal reference range is 4.8-10.8. On 12/5/07, at 10:25 PM, the floor nurse documented "will take pictures of legs and place in chart." The pictures of the resident's legs were reviewed. The picture of the wound of the left lower leg revealed a wound that was approximately 4.5 centimeters in width, with an area approximately 2 centimeters in width in the middle of the wound that was yellow and purulent in appearance. The wound on the left leg was cultured with the following bacteria identified: many white blood cells and many gram positive cocci. On 12/6/07, at 5:30 PM, the progress notes by the physician documented "most likely sepsis...source is either left leg or aspiration pneumonia. Chest x-ray not consistent with aspiration pneumonia like last patients hospital stay". On 12/10/07, licensed practical nurse (LPN) #1 was interviewed. She stated that she had written the nurses notes entry dated 12/3/07, 3:20 AM, and that the Band-Aid was a regular sized Band-Aid on the resident's left lower leg. She stated that the skin around the Band-Aid was not reddened or inflamed so she did not change the Band-Aid. She stated that the nurse from the previous shift had told her that the resident had a skin tear. On 12/10/07, the Director of Nurses (DON) was interviewed. She stated that there were different treatments for skin tears, depending on the wound. She stated that when an op-site	F 309	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; • Audit of all residents for undiscovered skin issues. • Residents with issues will be referred to the wound nurse for treatment orders. What measure will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur; • All residents will have a weekly skin check by the licensed staff and a daily skin check by the certified aides.	

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F 309	Continued From page 3 (occlusive, plastic dressing) was used, it was changed if any drainage or redness was noted. The op-site would be left in place until the skin healed if there were no signs or symptoms of infection. She stated that steri-strips were used if the tears edges needed to be pulled together and that they were left in place until they came off. She stated that non-stick dressings were used to prevent further trauma to the skin, and they were changed on a daily or twice daily schedule. She stated that there was not another event report for a skin tear for this resident. On 12/10/07, LPN #2 and a CNA who worked the resident's unit were interviewed. LPN #2 did not recall that the resident had a skin tear to his left leg prior to his transfer to the hospital. The CNA did not recall that the resident had a skin tear. LPN #2 stated that skin tears are treated with a dressing, and op-site, or steri-strips as appropriate for the wound. He stated that an event form is filled out when a resident sustains a skin tear. On 12/11/07, the assistant director of nurses was interviewed. She stated that if a skin tear needed treatment, for example, steri-strips, an incident report would be filled out. She stated that if no treatment was needed, the documentation would be in the nurses notes. On 12/11/07, the facility's wound nurse was interviewed. She stated that the resident had Velcro straps on his wheelchair, and that because of his leg movements, the straps sometimes caused abrasions. She stated that these were usually treated by putting a Band-Aid on the wound and that it would be healed in a day or two with no other treatment. She stated that the	F 309	• Areas of concern will be reported to the wound team/nurse, who will obtain treatment orders. • DON will review incident reports daily to determine injuries, and those injuries will be discussed at morning IDT meeting. • Any injuries will be placed on the treatment sheets and monitored daily for improvement.	

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F 309	Continued From page 4 resident was not being treated for any skin tears, and that he was not on the wound report for the week ending 11/30/07 or the week ending 12/7/07. She stated that as wound nurse she does check all reported skin tears and abrasions. The resident's medical record was reviewed. The resident's care plan for preventing skin breakdown included the following approach, "resident's skin will be monitored biweekly by CNAs on shower days, weekly by nursing and with each incontinent episode." Review of the resident's treatment plan for weekly skin check revealed that boxes indicating 11/3/07, 11/10/07, 11/17/07, and 11/24/07 as the dates for his weekly skin checks. The boxes on the treatment plan record were not initialed or marked in any way. The box for 12/5/07 was initialed and circled, with a note on the back of the form, "out to hospital". The resident's vital signs for 12/5/07 for the night shift of 12/5/07 were documented as temperature 98.0, pulse 105, respirations 24, blood pressure 148/54. The day shift vital signs for 12/5/07 were documented as temperature 97.3, pulse 102, respirations 24, and blood pressure 124/65.	F 309	How will you monitor the corrective action to ensure that the deficient practice will not recur; • Every chart will be reviewed monthly at Quality of Care meeting to include skin assessments. • Skin issues and pressure ulcers will be tracked and trended for review at monthly Performance Improvement. Completion date: December 28, 2007 Monitored by the DON	